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PATIENT REQUEST FOR MEDICAL RECORDS

(Use when giving records to patient or another physician)
Please allow 7 - 14 days to process your request

**** THE REQUESTED INFORMATION WILL NOT BE RELEASED WITHOUT THE APPROPRIATE SIGNATURE ****

PATIENT(S) LEGAL NAME	DATE OF BIRTH

INFORMATION REQUESTED:

ALL RECORDS (mail or pickup only)

SHOTS ONLY

DATE(S) OF SERVICE: _____

OTHER:

REASON FOR THE REQUEST:

TRANSFERRING TO:

CONSULTATION TO:

MOVING TO:

OTHER:

MAIL to address under "Reason for Request"

PARENT / GUARDIAN / PATIENT TO PICK UP

FAX (limited / urgent only) # _____

IF REQUESTED RECORDS ARE GIVEN TO SOMEONE OTHER THAN THE PARENT, LEGAL GUARDIAN OR PATIENT, THE AUTHORIZATION FOR USE / DISCLOSURE FORM MUST BE COMPLETED AND SIGNED BEFORE RECORDS MAY BE SENT. FEES BELOW WILL APPLY.

Please provide address for above:

CHARGES FOR COPYING MEDICAL RECORDS You have requested that West End Pediatrics, P.C. either release your medical information or a summary of your information to a person or entity outside of our practice or that you would like to have a copy of your medical records. In accordance with Virginia law, West End Pediatrics, P.C. may charge you a reasonable fee for this service regarding non-subpoenaed medical records. **1) For copies from paper or other hard copy generated from computerized or other electronic storage, West End Pediatrics, P.C. charges: 50 cents per page for first 50 pages; 25 cents per page for additional pages** **2) Cost of shipping / postage** **3) \$5.00 / form for completing school, daycare, sports, etc. forms.** If medical records are subpoenaed, the party causing the subpoena is responsible for payment of the rates listed above under #1. If you feel you cannot afford to pay our posted charges, please call our Business Office (804) 740-2527 to discuss a payment plan or an alternative arrangement. Thank you.

I understand that once this information is released by West End Pediatrics, P.C., the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

Signature of Parent, Patient or Legal Guardian _____ Date _____

Print Name _____ Relationship to Patient _____